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To the Honorable Justices of the Supreme Court of the State of Michigan:

I had the honor to be one of "a group of ten of the nation's most prominent physicians in the area of pulmonary function" who was "interviewed at length at the Chicago offices" of the American Bar Association by the Commission on Asbestos Litigation, to establish a Standard for Non-Malignant Asbestos-Related Disease Claims. I have been involved in the evaluation and care, clinical research and epidemiology of asbestos-related diseases for over 40 years, with joint professorships in (Pulmonary) Medicine and Occupational Medicine. I have evaluated tens of thousands of asbestos-exposed workers in a variety of occupations, and cared for hundreds of patients with these diseases in my academic and private practices. I spent considerable time in the State of Michigan in the 1970's as part of the Mount Sinai Medical School (New York) survey of the medical effects of polybrominated biphenyls (PBB's) which had contaminated the food chain in your State. I have published more than 30 articles in peer reviewed journals and chapters in 5 textbooks on medical effects of asbestos. I currently sit on the American Thoracic Society Committee on Nonmalignant Asbestos Disease.

At first, I considered the interaction between our noble professions to be a rewarding one. It has not proven to be. The ABA Standard for Non-Malignant Asbestos-Related Disease Claims does not reflect my statements or my many years of experience and research in these diseases, although my name and academic affiliation are listed therein. I received no advance draft of the Standard for my input.

The Supreme Court of the State f Michigan is considering use of the ABA "Standard" to establish an Inactive Asbestos Docket. I feel it necessary to make it clear to this court that the "Standard" is not inclusive in insuring that valid claims of pulmonary impairment are admitted into the system, as it attests.* Rather, it is exclusionary and bars claims for many characteristic manifestations of such impairment.

1. Significant asbestosis can be present with barely detectable or no findings on an x-ray read by a B-reader (an x-ray profusion on the International Labour Office Classification less than 1/0 or even a normal x-ray). Impairment from this asbestosis can be manifest

by pulmonary function tests, e.g., demonstrated decrease in forced vital capacity (FVC), total lung capacity (TLC), or diffusing capacity (DL) (with or without a decrease in forced vital capacity), or abnormality in ventilatory and gas exchange parameters on respiratory exercise testing. Diffusing capacity is available at any lung center, is standardized [(1)] and is known to be abnormal in interstitial lung disease (ILD) even when FVC and x-ray are normal. The ABA "Standard" makes no reference to diffusing capacity or respiratory exercise testing. Perversely therefore, if DL is significantly decreased without a decrease in FVC, the X-RAY REQUIREMENT OF THE ABA STANDARD IS EVEN HIGHER (2/1).

Impairment from asbestos can be manifest by the pulmonary function test to which the ABA pays most attention, the FVC, when the x-ray is normal; such impairment is not admissible under the ABA proposal.

Asbestosis can be detected radiographically by CT scan when the x-ray is normal. CT scan is universally available in the U.S. and used by all pulmonologists in the assessment of ILD.

2. The section on impairment from asbestos-related pleural scarring is vastly insufficient. The ABA admits only bilateral diffuse pleural scarring of major degree. Diffuse pleural scarring can be associated with greatly diminished FVC regardless of the extent or thickness of the scarring on x-ray or its bilaterality [(2)]. It is therefore exclusionary to insist on "bilateral" diffuse pleural thickening of at least B/2.

   Circumscribed pleural scarring (also known as pleural plaques) comprises the vast majority of cases (80-85 percent. of patients with pleural scarring). The ABA bars all cases of circumscribed pleural scarring regardless of extent or thickness. Analysis of large numbers of patients has shown that extensive circumscribed pleural scarring (plaques) can be associated with a significant decrement in FVC sufficient to bring about impairment in individual patients.

3. Impairing asbestosis and asbestos-related pleural scarring can co-exist with the most common pulmonary imparirment, obstructive airways disease. Asbestos inhalation can cause some degree of airways obstruction by itself [(3,4)] Evidence also points to an interaction between asbestos and the most common cause of airways obstruction, cigarette smoking, in bringing about a combined (restrictive-obstructive) ventilatory impairment. [(5)] Another common cause of airways obstruction is asthma. The mere finding of airways obstruction should not bar a demonstrated claim for non-malignant asbestos disease, any more than the presence of other common comorbidities like high blood pressure or diabetes.

It is my hope that the considerations I have raised will cause re-evaluation of the ABA "Standard" in your necessary effort to create an Inactive Asbestos Docketing System.

Most sincerely,

Albert Miller, MD

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*"The Standard adopts less restrictive alternatives than some physicians recommended. The Commission recognizes that the effect of this may be to allow claims that do not really belong in the tort system, but PREFERS TO TAKE THAT APPROACH RATHER THAN TO UNFAIRLY EXCLUDE ANY SIGNIFICANT NUMBER OF DESERVING CLAIMS."

References:

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3. Rodriquez-Roisin R, Merchant JE, et al. Maximal expiratory flow-volume curves in workers exposed to asbestos. Respiration 1980; 39:58.
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5. Miller A, Lilis R, et al. Spirometric impairments in long-term insulators. Chest 1994; 105:175.